MEDICAL LIABILITY RELEASE FORM

DIRECTIONS: Due to legal restrictions, it is necessary that all delegates, parents/guardians, guests and HOSA advisors complete this form to be eligible to attend all Utah HOSA and National HOSA events. The copies should be retained by the local advisor unless otherwise requested.

PLEASE TYPE OR PRINT ALL INFORMATION

Delegate *Parent/Guardian*

Name:_____ Name:_____

Home Address:_____

Parent/Guardian Telephone: Home:_____ Work:_____

Student's Physician:_____ Phone:_____

Physician's Address: _____

Alternate Contact:_____

Telephone Number: Home:_____ Work:_____

Local Advisor: _____ School Name:_____

Student is covered by group or medical insurance: _____Yes _____No

If yes, complete the following information:

Name of insured:_____ Insurance Company:_____

Group #: _____ Policy #:_____

Please completely describe any medical condition which may recur or be a factor in medical treatment:

a. Allergies:_____ e. Physical Handicap:_____

b. Convulsions:_____ f. Medicine Reactions:_____

c. Blackouts:_____ g. Disease of Any Kind:_____

d. Heart/Lung Problems: _____ h. Other (Be specific): _____

If currently taking medication, please provide the following information:

Name of Medication(s):_____

Prescribing Physician Phone Number: _____

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her own insurance coverage during this trip. I hereby release the National HOSA Board of Directors, the National Staff, Utah State HOSA and Local HOSA Associations, and any designated individual in charge of the HOSA group or specific activity form any legal or financial responsibility with respect to my personal or my student/child's participation in or contact with any know element associated with an activity including competitive events.

PARENT/GUARDIAN: Please check one of the following and sign your name.

❑ I give permission for immediate medical treatment as required in the judgement of the attending physician. Notify me and/or any persons listed above as soon as possible.

❑ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature:_____Date: _____

(Applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Delegate's Signature:_____Date: _____

Advisor's Signature: _____ Date: _____